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A Study of School-age Children for Whom Service Was Terminated with the Chattanooga Psychiatric Clinic between July 1, 1961, and June 30, 1963

John Paul Baggett
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To the Graduate Council:

I am submitting herewith a thesis written by John Paul Baggett entitled "A Study of School-age Children for Whom Service Was Terminated with the Chattanooga Psychiatric Clinic between July 1, 1961, and June 30, 1963." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science in Social Work, with a major in Social Work.

Dana L. Ingle, Major Professor

We have read this thesis and recommend its acceptance:

Jane Ann Epperson, Hugh H. Vaughn

Accepted for the Council:
Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

May 10, 1965

To the Graduate Council:

I am submitting herewith a thesis written by John Paul Baggett entitled "A Study of School-age Children for Whom Service Was Terminated with the Chattanooga Psychiatric Clinic between July 1, 1961, and June 30, 1963." I recommend that it be accepted for nine quarter hours of credit in partial fulfillment of the requirements for the degree of Master of Science in Social Work.

Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:

Dean of the Graduate School

A STUDY OF SCHOOL-AGE CHILDREN FOR WHOM SERVICE WAS TERMINATED WITH THE CHATTANOOGA PSYCHIATRIC CLINIC BETWEEN JULY 1, 1961, AND JUNE 30, 1963

A Thesis

Presented to

the Graduate Council of

The University of Tennessee

In Partial Fulfillment

of the Requirements for the Degree

Master of Science in Social Work

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by

John Paul Baggett

June 1965

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CHAPTER I

INTRODUCTION

I. THE SETTING

The Chattanooga Psychiatric Clinic is a medical clinic with a multidisciplinary staff composed of psychiatrists, psychologists, and psychiatric social workers. It serves as the only outpatient psychiatric community clinic in southeastern Tennessee, northern Georgia, and northeastern Alabama.

The Clinic was organized in 1947 and is sanctioned under the charter of the Mental Health Association of Hamilton County.[1] In January, 1965, the name of the Clinic was changed by the Board of Directors from the Chattanooga Guidance Clinic to the Chattanooga Psychiatric Clinic. The Clinic is a non-profit organization with no eligibility restrictions as to race, religion, or economic level. Financial support is received from federal, state, county, and city funds, with additional support from the United Fund, patient fees, and contributions.

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[1]Mrs. Clarence Shaw, "History of the Chattanooga Guidance Clinic" (Chattanooga Guidance Clinic, 1955), p. 3. (Mimeographed.)

Clinic policy is determined by a thirty-three member Board of Directors--citizens who are concerned with providing excellent outpatient psychiatric services to the people of the Chattanooga area. The Board of Directors has no direct relationship or contact with professional procedures as these relate to patient care. The Director of the Clinic is responsible to the Board for providing adequate treatment of patients, developing services, and for maintaining high level professional ethics, courtesy, and confidentiality.

The primary function of the Clinic is to provide diagnostic and treatment service for children and adults with emotional illnesses--psychoneurotic, pre-psychotic, and personality disorders--and for those with suspected brain damage or mental deficiency.[2] In fulfilling this purpose, the Clinic works closely and directly with various agencies and groups in the local and regional community, acting as a consultative resource, as well as working directly with patients. The Clinic finds it necessary continuously to interpret the Clinic program to the community so that maximum appropriate use of the clinic service can

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[2]Sylvia L. Faulkner and Gwenneth L. Price, "A Comparative Study of Characteristics of Patients Seen and Service Rendered at the Chattanooga Guidance Clinic During 1954-55 and 1959-60" (unpublished Master's thesis, The University of Tennessee, Knoxville, 1962), p. 1.

be effected. Also, the Clinic has found it necessary to modify procedures from time to time in order to meet community needs as they change.

A secondary function of the Clinic is in the area of education. The Clinic cooperates with the Mental Health Association in a program of public education.[3] The Clinic conducts training sessions for groups such as nursery school teachers, visiting teachers, and lay people. In addition, the Clinic conducts seminars and conferences for the educational development of its professional staff. During the period studied, Clinic personnel was involved in over 2,500 hours of community projects in the area of education.[4] The Clinic is also used as a training center for extern psychiatrists and psychologists, and for students in field work training in psychiatric social work.[5]

During the period studied, the professional staff consisted of three psychiatrists, three psychologists, and three psychiatric social workers.

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[3]Statement by Edward Tiller, Mental Health Association of Hamilton County, in speech on December 15, 1964.

[4]From statistical reports filed with the Tennessee Department of Mental Health.

[5]Faulkner and Price, op. cit., p. 2.

II. CLINIC PROCESS

The Clinic makes use of the "team approach" in serving patients. The skills of each discipline--psychiatry, psychology, and social work--are coordinately utilized in evaluating and treating each patient.

The patient, or a family member, makes initial contact with the Clinic by telephone. Telephone intake calls are handled by the psychiatric social workers, who determine the nature and extent of the patient's problem. If the patient's problem is of the type which the Clinic is equipped to handle, the social worker places the patient on a waiting list such as the "priority," "early appointment," or the "regular" waiting list. However, if in the social worker's judgment the patient's problem presents an emergency the social worker arranges for the patient to be seen as soon as possible--often the same day of the call or within a day or two.

Following telephone intake, the clinic process involves three phases--intake, evaluation, and treatment. Intake may require one or several interviews with a psychiatric social worker, who obtains the social history and information about the situation leading up to the illness. The social worker also assists the patient in clarifying his own ideas of his need for clinic services, obtains a clear picture of the

presenting problems, orients the patient regarding clinic policy, and establishes a fee according to the patient's ability to pay.

Following intake, the social worker prepares a summary of his findings, which is reviewed by the Screening Committee, which consists of the chiefs of each discipline. The Screening Committee determines how the patient may be best helped--whether further diagnostic studies are necessary, whether the Clinic is the facility which can best give services to the patient, or whether psychological testing is indicated. If it is determined that the Clinic is not the agency that can best give service to the patient, the appropriate referral is made.

If the Clinic is the facility that can best give service to the patient, the patient is then evaluated. If the patient is a child, the child's parents may be evaluated or be seen by a social worker while the child is being evaluated. Evaluations are made by either a psychiatrist or a clinical psychologist. Diagnostic testing is done by a psychologist.

After evaluation, the case is presented at Staff Conference in which all professional staff members have the opportunity to participate in discussion of the case before a final diagnostic impression is formulated and recommendations are made. Recommendations might include treatment at

the Clinic for the patient, referral of the patient elsewhere, or that no treatment be offered. If treatment at the Clinic is recommended, the staff defines goals and assigns a therapist, who is chosen from one of the disciplines on the basis of appropriateness of his skills to the case.

III. PURPOSE AND FOCUS OF STUDY

One of the major problems of the Chattanooga Psychiatric Clinic has been to determine the most efficient method of extending services to the emotionally disturbed person.[6] In order to improve services, the Clinic must have a clear and precise picture of the social characteristics of patients served, their problems, who referred them, what services were rendered, what use was made of the Clinic, and what disposition was made of the case.

Since 50 per cent of the Clinic's diagnostic work is with children and their parents, it was thought important to make an analysis of a representative group of children served by the Clinic.

The Clinic defines a child as any person under eighteen years of age, and the majority of children served by the Clinic are between the ages of six and eighteen.

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[6]Faulkner and Price, op. cit., p. 5.

These ages correspond with the usual years of school attendance, and it was believed that almost all children in this group would be students. Therefore, it was decided to divide this group into two categories--those referred to the Clinic by schools and those referred by sources other than schools (hereafter referred to as "other sources") and to determine if any differences could be found in the children referred by these two referral groups, in a variety of characteristics.

It was thought that many children might be referred to the Clinic at about age six or seven since entrance into school is an event in the child's life that causes some stress or is the point at which problems a child may have become apparent. Often a shift from elementary to junior high school either helps to create or to make evident some emotional problem of the child. Therefore, it was thought that many referrals would be of children who had just recently entered junior high school.

It was thought that children referred by schools might differ in social characteristics and presenting problems from those referred by other sources. This was on the basis that schooling is an almost universal experience in our society and the school population is representative of the population as a whole, whereas other sources of referral

might, by their nature, have contact with some special segment of the population.

This study was designed to investigate the following hypotheses:

1. Referrals of children to the Clinic will tend to cluster around two time points--school entrance and the shift from elementary to junior high school.
2. Proportionately, more school referrals than those referred by other sources will be of children in the lower socio-economic class.
3. Children referred by schools will terminate service earlier in the clinic process than those referred by other sources.
4. Proportionately, more children from one-parent families will be referred by other sources than by schools.
5. There will be more referrals of children who are the oldest child in the family (or the only child) than of younger siblings.
6. There will be no difference in the proportion of oldest children referred by schools and those referred by other sources.

IV. SCOPE AND METHOD OF STUDY

This study was limited to an analysis of certain characteristics of children, ages six through seventeen, who terminated clinic contact between July 1, 1961, and June 30, 1963.

To obtain the sample for this study, the case numbers of terminated cases in this age group were recorded from lists kept by the Clinic for statistical purposes of the Tennessee Department of Mental Health. Three hundred and sixty-two cases were terminated during the period studied. Because of the relatively short amount of time available for this study, it was decided to select a sample of approximately one-half this total. Selecting every second case produced 181 cases. In order to have a round number of cases with which to work, every tenth case of the remaining 181 cases was selected, which gave a total sample of two hundred cases.

In collecting data, it was necessary, for each patient studied, to obtain information from two sources--statistical cards kept by the Clinic and the case record. As the data were collected and recorded, the cases were separated as to source of referral.

Simple percentages were used in comparing various data where size of numbers made this appropriate. In some

instances, a chi-square was figured to test the significance of differences found between the two groups of children.

CHAPTER II

CHARACTERISTICS OF PATIENTS

Comparisons of those children referred by schools with those referred by other sources were made on the following characteristics: age, race, sex, religion, grade achievement, family income, fees, living arrangements, and ordinal rank of patient in regard to siblings. Additional information obtained from each case record included source of referral, reason for referral, diagnosis, how far the patient progressed in the clinic process, number of interviews conducted, and disposition of case.

According to the bylaws of the Chattanooga Psychiatric Clinic, there were no residence, racial, religious, or economic barriers to service at the Clinic during the period studied. This policy had been in effect since the beginning of the Clinic's operations.

I. SEX

Of the two hundred children studied, it was found that one hundred twenty were male and eighty were female. Thirty-eight patients were referred by schools, of whom twenty-eight were male and ten were female. Of the 162 patients referred by other sources, ninety-two were male and

seventy were female. It is interesting to note that schools referred a larger proportion of males than did other sources. Seventy-three and six-tenths per cent of the school referrals were males, whereas of referrals from other sources, 56.8 per cent were males. Tested by chi-square, however, the difference proved not significant. Table I shows the age distribution according to the age and sex of the patient.

II. RACE

Of the two hundred children studied, 171 were white and twenty-nine were Negro. Schools referred thirty white children and eight Negro children. Other sources referred 141 white children and twenty-one Negro children. Two interesting statistics are revealed in these figures: (1) the twenty-nine Negroes in this study represent 14.5 per cent of the total sample. This represents an increase in proportion of Negro patients seen by the Clinic, in comparison with findings of two other studies made in this area. In a study made in 1957, only 7 per cent of total patients were Negro[1] and a study made in 1962 indicates that 11 per

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[1]June J. Casey, et al., "A Study of the Cases Referred to the Chattanooga-Hamilton County Guidance Clinic From July 1, 1954 through June 30, 1955" (unpublished Master's thesis, the University of Tennessee, Knoxville, 1957), p. 10.

TABLE I

DISTRIBUTION OF PATIENTS BY AGE, SEX, AND RACE

Age	White		Negro		Total		Total	
	Male	Female	Male	Female	Male	Female	White	Negro
6- 7	19	10	2	2	21	12	29	4
8- 9	21	10	5	2	26	12	31	7
10-11	15	7	6	2	21	9	22	8
12-13	11	13	1	2	12	15	24	3
14-15	24	11	1	1	25	12	35	2
16-17	11	19	4	1	15	20	30	5
Total	101	70	19	10	120	80	171	29

cent of the total patients were Negro;[2] (2) Schools referred more Negroes than did other sources. This latter fact is partly explained by the fact that there were more Negro visiting teachers in Chattanooga during the period studied than in the periods covered by previous studies.

The steady increase in Negro patients served can be explained by the fact that recently the Negro population has received more interpretation of Clinic services in the Chattanooga area than was true several years ago. For example, Negroes are serving on the Board of Directors of the Clinic and there is more active participation in group meetings, seminars, and projects conducted by the Clinic.

Despite the increase in proportion of Negro patients served, the Clinic use by Negroes, 14.5 per cent of cases studied, is considerably lower, proportionately, than Negro population which was approximately 29 per cent of the total population in 1960.[3]

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[2]Sylvia L. Faulkner and Gwenneth L. Price, "A Comparative Study of Characteristics of Patients Seen and Service Rendered at the Chattanooga Guidance Clinic During 1954-55 and 1959-60" (unpublished Master's thesis, The University of Tennessee, Knoxville, 1962), p. 15.

[3]Ibid., p. 19.

III. AGE

Table I indicates that the two hundred patients studied were somewhat evenly distributed among the six age groups. It was predicted that distribution would cluster at ages six and seven and at ages twelve and thirteen, which are the points of a child's entrance into school and the shift from elementary to junior high school. These ages correspond roughly with the beginning of latency and adolescence. However, the distribution clustered at ages eight and nine, thirty-eight patients, and at ages fourteen and fifteen, thirty-seven patients. The fewest number of patients, twenty-seven, were found in the twelve and thirteen age group.

Table I also shows that the cases were evenly distributed between latency-age children and adolescents, 101 latency-age patients and ninety-nine adolescent patients. Table II shows twenty latency-age children and eighteen adolescents among those cases referred by schools. Table III shows eighty-one patients in each group, latency-age children and adolescents.

Schools tended to refer the adolescent girl more frequently than the latency-age girl, at a rate of seven to three. Schools referred as many white children of latency

TABLE II

DISTRIBUTION OF PATIENTS REFERRED BY SCHOOLS
BY AGE, SEX, AND RACE

Age	White		Negro		Total		Total	
	Male	Female	Male	Female	Male	Female	White	Negro
6- 7	3	1	1	0	4	1	4	1
8- 9	4	0	2	1	6	1	4	3
10-11	4	1	3	0	7	1	5	3
12-13	3	3	0	1	3	4	6	1
14-15	5	1	0	0	5	1	6	0
16-17	3	2	0	0	3	2	5	0
Total	22	8	6	2	28	10	30	8

TABLE III

DISTRIBUTION OF PATIENTS REFERRED BY OTHER SOURCES BY AGE, SEX, AND RACE

Age	White		Negro		Total		Total	
	Male	Female	Male	Female	Male	Female	White	Negro
6- 7	16	9	1	2	17	11	25	3
8- 9	17	10	3	1	20	11	27	4
10-11	11	6	3	2	14	8	17	5
12-13	8	10	1	1	9	11	18	2
14-15	19	10	1	1	20	11	29	2
16-17	8	17	4	1	12	18	25	5
Total	79	62	13	8	92	70	141	21

age as they did white adolescents. Schools referred only one Negro adolescent.

Other sources referred nine adolescent Negroes and twelve latency-age Negroes. Of the twenty-nine Negroes in this study, nineteen were latency-age children and ten were adolescents. The fact that schools referred only one Negro adolescent may be explained by the fact that Negro teachers and school officials in the elementary grades participate in Clinic programs more actively than those teachers in the higher grade levels. Therefore, they are more aware of Clinic services and the need for these services on the part of the children they see. Also, the school drop-out rate among Negroes over age twelve could account for fewer referrals of patients in that group.

IV. RELIGION

Data from Table IV indicate that an overwhelming majority of patients referred were of the Protestant faith. There was so little difference between the two referral groups regarding religious affiliation that no conclusion can be drawn except the obvious one that patients from both groups reflect the strongly Protestant make-up of the community.

TABLE IV

DISTRIBUTION OF PATIENTS BY RELIGIOUS AFFILIATION AND SOURCE OF REFERRAL

Religion	Referred By Schools	Referred By Other Sources	Total
Protestant	34	141	175
Catholic	1	4	5
Jewish	1	2	3
None	0	5	5
Not available	2	10	12
Total	38	162	200

V. GRADE ACHIEVEMENT

For this characteristic, it was decided to determine if the child was in the appropriate grade for his attained age or if he was lagging in school grade. In order to determine this, the child's birthdate was obtained and from this it was determined when he should normally have entered the first grade of school. Knowing when the child entered the first grade, it was easily determined if the child was in the appropriate grade or if he was lagging. For example, a child born in June, 1955, should have entered the first grade in September, 1961. If he sought the Clinic's service in October, 1962, he should normally have been in the second grade. If the case record indicated that he was in the second grade, then it was assumed that he was in the appropriate grade. If the case record indicated that he was in the first grade, then he was considered to be lagging.

Of the thirty-eight school referrals, it was found that twenty-six, or 68.4 per cent, were lagging in grade achievement and that nine, or 23.7 per cent, were in the appropriate grade. Two patients were in special education classes and one case record did not indicate the grade of the patient.

Of the referrals from other sources, it was found that eighty-two, or 50.6 per cent, were lagging and that

sixty-one, or 37.6 per cent, were in the appropriate grade. Three patients were in special education classes and in sixteen case records the child's grade was not indicated.

Schools tended to refer the child who was lagging in grade achievement. This may indicate that learning problems rather than behavioral problems were a primary reason schools referred a patient. Table V shows the grade achievement of the entire sample of children studied according to source of referral.

VI. FAMILY INCOME AND FEES

The entire two hundred cases were divided into income categories as shown in Table VI. The two categories of referral sources were about even in regard to referring lower class patients. The $4,000 mark was arbitrarily selected to divide the lower and upper income classes. Of the school referrals, 50 per cent were from lower income groups as compared with 55 per cent of those from other sources who had lower incomes. While the average income of thirty-seven school referrals was $4,530, the median income was $3,750. The average income of one hundred fifty referrals from other sources was $3,658, but the median income was $3,000. Figures were not available for one school referral and for twelve referrals from other sources. The

TABLE V

DISTRIBUTION OF PATIENTS BY GRADE LEVEL AND SOURCE OF REFERRAL

Status	Referred By Schools	Referred By Other Sources	Total
In appropriate grade	9	61	70
Lagging	26	82	108
None	1	7	8
Special Education	2	3	5
Total	38	162	200

TABLE VI

DISTRIBUTION OF PATIENTS BY FAMILY INCOME AND SOURCE OF REFERRAL

Income	Referred By Schools	Referred By Other Sources	Total
Less than $2,000	10	49	59
$2,000- 3,999	9	40	49
$4,000- 5,999	7	39	46
$6,000- 7,999	5	10	15
$8,000- 9,999	2	7	9
$10,000-11,999	4	6	10
Over $12,000	1	6	7
Not available	0	5	5
Total	38	162	200

average income for the 187 cases for which figures were available was $3,777.

It was predicted that more lower class referrals would be made by the schools. Considering income as indicating social class, this hypothesis was not supported by the data.

Table VII shows that of the entire group of two hundred patients, 123, or 61.5 per cent, paid fees of less than four dollars. Of school referrals, twenty-two, or 58 per cent, paid fees of less than four dollars, as compared with 62.3 per cent of referrals from other sources. Twenty-three per cent of the entire group were indigent, paying no fee. One-third of the total patients paid a fee of fifty cents or less. These figures are comparable to figures given by a similar agency, the Knoxville Mental Health Center, in that their median income per family was $3,300 and 19 per cent of their patients were indigent.[4]

VII. LIVING ARRANGEMENTS

It was predicted that more children from one-parent families would be referred by other sources than by schools. Data from Table VIII show that of the 162 referrals from

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[4]News item in the Knoxville News-Sentinel, February 28, 1965.

TABLE VII

DISTRIBUTION OF PATIENTS BY FEES AND SOURCE OF REFERRAL

Fee	Referred By Schools	Referred By Other Sources	Total
None	9	37	46
$.50- .99	1	19	20
$1.00-1.99	4	14	18
$2.00-2.99	4	12	16
$3.00-3.99	4	19	23
$4.00-4.99	2	17	19
$5.00-5.99	4	15	19
$6.00-6.99	0	6	6
$7.00-7.99	3	6	9
$8.00-8.99	1	4	5
$9.00-9.99	1	2	3
$10.00 or over	5	8	13
Not available	0	3	3
Total	38	162	200

TABLE VIII

DISTRIBUTION OF PATIENTS BY LIVING ARRANGEMENTS AND SOURCE OF REFERRAL

With Whom Child Lives	Referred By Schools	Referred By Other Sources	Total
Both parents	26	110	136
Mother	8	41	49
Father	1	3	4
Other	2	8	10
Not available	1	0	1
Total	38	162	200

other sources, forty-four, or 27.2 per cent, were from one-parent families. Only nine, or 24.3 per cent, of the children referred by schools and for whom living arrangements were known were from one-parent families. Chi-square computation proves this difference to be negligible.

VIII. ORDINAL RANK

It is popularly believed that the oldest child in a family is more likely to have emotional problems than younger siblings. The reason for this belief is that parents of a first-born child are likely to be more tense and anxious in rearing the first child than in rearing later ones. Therefore, in this study, it was expected that more children would be the oldest child in the family than the younger. Of the entire group, ninety-seven children were the oldest child, forty-four were the youngest, and fifty-eight were neither the oldest nor the youngest. Of those referred by schools, 54 per cent were the oldest child as compared with 47.5 per cent of oldest children referred from other sources. Data from Table IX show that the "oldest" category is the largest individual category, but it is not larger than the combined categories of "youngest" and "neither."

TABLE IX

DISTRIBUTION OF PATIENTS BY ORDINAL RANK OF PATIENT IN RELATION TO SIBLINGS AND SOURCE OF REFERRAL

Rank	Referred By Schools	Referred By Other Sources	Total
Oldest	20	77	97
Youngest	10	34	44
Neither	7	51	58
Not available	1	0	1
Total	38	162	200

CHAPTER III

USE MADE OF THE CLINIC

I. SOURCE OF REFERRAL

As previously stated, the two hundred patients were divided into two broad categories: thirty-eight patients were referred by schools and 162 patients were referred by other sources.

The thirty-eight patients referred by schools represent 19 per cent of the universe. It is a general opinion among this Clinic's personnel that this figure is a distorted one because many people give themselves or another place or person as the one who made the referral when in reality the school made the original suggestion. The figure of 19 per cent compares favorably with findings from a similar study made at the Child Guidance Clinic in Los Angeles which indicated that 15 per cent of the patients in a similar age group were referred by schools.[1]

The referral source designated as "other" was subdivided into four categories. Of the 162 referrals, twelve

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[1]Forrest N. Anderson and Helen C. Dean, Some Aspects of Child Guidance Clinic Intake Policy and Practices, United States Department of Health, Education, and Welfare, Public Health Monograph No. 42 (Washington: Government Printing Office, 1956), p. 3.

were referred by the court, seventy-six were referred by doctors and medical facilities, fifty-eight were referred by parents, and sixteen were referred by relatives, ministers, social agencies, etc. An interesting point to make regarding these sources is that 47 per cent of the patients were referred by doctors and medical facilities as compared with 25 per cent in the study made by Faulkner and Price.[2] This reflects a trend in the Chattanooga area in that doctors and medical facilities are making better use of the Clinic's services and that Clinic services are interpreted to professional persons in a better manner than before.

II. REASON FOR REFERRAL

In each case record studied, the child's presenting problem was obtained. In most cases, two or more presenting problems were given. In fact, 467 presenting problems were given for the two hundred patients. In order to simplify the study, only the major reason for referral was used in this analysis.

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[2]Sylvia L. Faulkner and Gwenneth L. Price, "A Comparative Study of Characteristics of Patients Seen and Service Rendered at the Chattanooga Guidance Clinic During 1954-55 and 1959-60" (unpublished Master's thesis, The University of Tennessee, Knoxville, 1962), p. 38.

The presenting problems were divided into four categories, those being the same categories as were used in the Los Angeles study.[3] Group I included those problems of an actual, concrete, and specific nature that would be recognized and labelled by essentially the same term regardless of who described the behavior. Examples of problems in this group were thumbsucking, temper tantrums, fighting, and stealing. Problems in Group II included those shown by rather definite behavior but possibly having different connotations for different people. Examples of problems in this group were "hard to discipline," "cries easily," "daydreaming," and "rebellious." Problems in Group III included those problems described by abstractions and generalities such as the terms unhappy, jealous, stubborn, and maladjusted in school. Group IV problems were very broad generalizations and included symptoms of physical conditions. Examples were nervousness, insecurity, frustration, retardation, and "learning" problems.

Presenting problems are shown in Table X according to symptom classification. Approximately 60 per cent of the symptoms fell into Groups I and IV, in contrast to the findings of the Los Angeles study, which showed only 35 per cent in those two groups. In the present study a much higher

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[3]Anderson and Dean, op. cit., pp. 6-8.

TABLE X

DISTRIBUTION OF PATIENTS ACCORDING TO SYMPTOM CLASSIFICATION AND SOURCE OF REFERRAL

Group Number	Referred By Schools	Referred by Other Sources	Total
Group I	9	52	61
Group II	10	22	32
Group III	13	34	47
Group IV	6	54	60
Total	38	162	200

percentage fell into Group IV, 30 per cent, as compared with 8 per cent in the Los Angeles study.[4] The reason for this large difference is that in the present study many more referrals were made by medical facilities and doctors who tended to use physical symptoms as their reason for referral. For example, a non-medical referral might give the presenting problem as "daydreaming" or "hard to discipline" which would fall into Group II, but a doctor or medical facility might suspect mental retardation or brain damage, with these symptoms falling into Group IV.

The two broad referral groups were quite different in presenting problems. Sixty and one-half per cent of the presenting problems of patients referred by schools fell into Groups II and III, while 65.3 per cent of the presenting problems of patients referred by other sources fell into Groups I and IV.

As stated previously, many patients presented more than one problem. However, for this study only the major presenting problem of each patient was used. The problems that were given most frequently as the major reason for referral were as follows: retarded, temper tantrums, poor school adjustment, hyperactive, school phobia, nervousness,

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[4] Ibid.

stealing, difficulty in interpersonal relationships, evaluation only, and rebelliousness.

III. DIAGNOSES OF PATIENTS STUDIED

Of the two hundred patients studied, a diagnosis was made on 165 patients while thirty-five patients were undiagnosed. Table XI shows the various diagnoses according to age group and source of referral.

Of the eighty diagnosed patients among latency-age children, 48.8 per cent were diagnosed as having personality disorders and 42.5 per cent were either mentally retarded or brain damaged. Of the eighty-five diagnosed adolescents, 62 per cent had personality disorders and only 16.5 per cent were mentally retarded or brain damaged. This indicates that most mentally retarded and brain damaged children are referred to the Clinic in their earlier years and, also, that this problem is quickly recognized in the early school years.

The child referred to the Clinic is most likely to be either mentally retarded/brain damaged or a personality disorder. These diagnoses represented 88.5 per cent of the patients referred by schools and 84 per cent of the patients referred by other sources.

TABLE XI

DISTRIBUTION OF PATIENTS ACCORDING TO DIAGNOSIS, LIFE STAGE OF DEVELOPMENT, AND SOURCE OF REFERRAL

Diagnosis	Latency		Adolescence		Total	
	Schools	Other	Schools	Other	Schools	Other
Mental deficiency or brain damaged	7	26	2	12	9	38
Personality disorder	5	35	9	44	14	79
Psychoneurotic	1	6	0	11	1	17
Schizophrenic	0	0	2	4	2	4
Psychophysiologic	0	0	0	1	0	1
Undiagnosed	7	14	5	9	12	23
Total	20	81	18	81	38	162

IV. STAGE IN CLINIC PROCESS

For each case studied, it was determined how far into the clinic process the patient proceeded. Table XII shows the distribution of patients in relation to diagnosis and referral category.

Of all patients studied, 34.5 per cent dropped out at intake, 46 per cent at evaluation, and only 19.5 per cent entered treatment. Patients referred by other sources accounted for 87 per cent of the cases which entered treatment, although other sources represented only 81 per cent of the universe. This may be explained by the fact that doctors, medical facilities, and the court referred 54 per cent of the patients in that category. It is the opinion of the Clinic's professional staff that these sources of referral are more proficient than other sources at recognizing mental problems and at making appropriate referrals.

Of the forty-eight children diagnosed as mentally deficient or brain damaged, thirty-nine were evaluated. However, only four of these children entered treatment and each of those was later referred elsewhere. Only five patients of the mentally deficient/brain damaged group dropped out at intake. This indicates that those in this group make good use of Clinic service.

TABLE XII

DISTRIBUTION OF PATIENTS BY DIAGNOSIS, STAGE OF CLINIC PROCESS, AND SOURCE OF REFERRAL

Diagnosis	Clinic Process			Total
	Intake	Evaluation	Treatment	
REFERRED BY SCHOOLS				
Mental deficiency or brain damaged	1	9	0	10
Personality disorder	5	5	3	13
Psychoneurotic	0	1	0	1
Schizophrenic	0	1	1	2
Psychophysiologic	0	0	0	0
Undiagnosed	11	0	1	12
Total	17	16	5	38
REFERRED BY OTHER SOURCES				
Mental deficiency or brain damaged	4	30	4	38
Personality disorder	21	39	19	79
Psychoneurotic	4	6	7	17
Schizophrenic	1	1	2	4
Psychophysiologic	0	0	1	1
Undiagnosed	22	0	1	23
Total	52	76	34	162

Those patients diagnosed as having personality disorders seem to drop out of Clinic services earlier than the patients in the other diagnostic categories, not including the mentally deficient/brain damaged or those undiagnosed. Only 24 per cent of the personality disorders entered treatment, although this diagnostic category accounted for 46 per cent of the total universe. This may be more easily understood if one considers the characteristics of personality disorders such as their undependability, unreliability, and their failure to recognize the fact that they have emotional problems.

Of the patients referred by schools, 44.7 per cent dropped out at intake as compared with 32 per cent of the patients referred by other sources. Only five of the thirty-eight school referrals, or 13 per cent, entered treatment as compared with 21 per cent of the patients referred by other sources. This indicates again that the referrals made by other sources tend to make better use of the Clinic's service.

V. NUMBER OF INTERVIEWS

The Clinic has a policy of treating the parents of a child at the same time the child is being treated, or of treating the child through the parents. Quite often, while a child is being tested or evaluated a social worker is

interviewing the parents. Only the parents are seen in the intake interviews. Therefore, the number of interviews shown in Table XIII includes the total number of interviews with both, parent and child.

Of the thirty-eight patients referred by schools, twenty-one, or 55 per cent, were seen for three or fewer interviews as compared with 40 per cent of the patients referred by other sources. It can be assumed that most of the cases seen less than three times dropped out at intake.

The child referred by other sources tends to remain in contact with the Clinic longer than the one referred by schools. Twenty-three per cent of school-referred patients are seen for seven or more interviews as compared with 30 per cent referred by other sources.

This can possibly be accounted for by the following facts: (1) the more seriously disturbed child is referred by other sources, which includes the grouping of doctors, medical facilities, and the court who tend to make the more appropriate referral than schools; and (2) schools refer more cases (31.5 per cent) that are undiagnosed and that drop out earlier than do other sources (14.2 per cent.)

VI. DISPOSITION OF CASES

Table XIV shows the distribution of cases according to diagnosis and the type of termination: patient terminated,

TABLE XIII

DISTRIBUTION OF PATIENTS BY DIAGNOSIS, NUMBER OF INTERVIEWS, AND SOURCE OF REFERRAL

Diagnosis	Number of Interviews			
	1-3	4-6	7 or more	Total
REFERRED BY SCHOOLS				
Mental deficiency or brain damage	3	3	4	10
Personality disorder	6	4	3	13
Psychoneurotic	0	0	1	1
Schizophrenic	1	0	1	2
Psychophysiologic	0	0	0	0
Undiagnosed	11	1	0	12
Total	21	8	9	38
REFERRED BY OTHER SOURCES				
Mental deficiency or brain damaged	12	19	7	38
Personality disorder	28	23	28	79
Psychoneurotic	4	3	10	17
Schizophrenic	0	2	2	4
Psychophysiologic	0	0	1	1
Undiagnosed	20	2	1	23
Total	64	49	49	162

TABLE XIV

DISTRIBUTION OF PATIENTS BY DISPOSITION OF CASE, DIAGNOSIS, AND SOURCE OF REFERRAL

Diagnosis	Patient Terminated	No Referral Elsewhere Clinic Terminated	Referred Elsewhere Clinic Terminated	Total
REFERRED BY SCHOOLS				
Mental deficiency or brain damaged	1	0	9	10
Personality disorder	10	1	2	13
Psychoneurotic	0	1	0	1
Schizophrenic	1	0	1	2
Psychophysiologic	0	0	0	0
Undiagnosed	12	0	0	12
Total	24	2	12	38
REFERRED BY OTHER SOURCES				
Mental deficiency or brain damaged	7	3	28	38
Personality disorder	36	26	17	79
Psychoneurotic	7	7	3	17
Schizophrenic	2	1	1	4
Psychophysiologic	1	0	0	1
Undiagnosed	20	0	3	23
Total	73	37	52	162

clinic terminated with referral elsewhere, or clinic terminated without referral elsewhere.

Of the two hundred cases studied, ninety-seven, or 48.5 per cent, were terminated by the patient. These patients referred by schools tended to terminate service themselves at a higher rate than those patients referred by other sources, 63.2 per cent versus 45.1 per cent. Of the ninety-seven patient-terminated cases, forty-six were personality disorders and thirty-two were undiagnosed. These two diagnostic categories accounted for seventy-eight, or 80.4 per cent, of the patient-terminated cases and also represented the highest rates of termination during intake and after three or fewer interviews. This might be explained by the fact that those patients who were not diagnosed did not proceed into the Clinic process far enough to be diagnosed and that the personality disorder, with his characteristics of unreliability, undependability, and possible failure to acknowledge emotional illness in himself, was not motivated for treatment.

Of the 103 Clinic-terminated cases, sixty-four were referred to another agency for service, while thirty-nine were terminated by the Clinic without referral to another agency.

Of the sixty-four cases referred elsewhere for service, thirty-seven, or 58.1 per cent, were diagnosed as

mentally deficient or brain damaged. Thirty-seven of the forty-eight mentally retarded or brain damaged patients, 77.1 per cent, were referred elsewhere for service, and this is in keeping with Clinic policy of referring a patient to the appropriate agency or the agency that can best help the patient. This Clinic is not designed nor equipped to serve this type of patient but does evaluate this type of patient.

Of the thirty-nine patients from whom service was terminated by the Clinic without referral elsewhere, thirty-three, or 84.6 per cent, were terminated with a notation that no further care was indicated. For the remainder, further care was indicated but was not available in the community.

Twenty-four patients were diagnosed as either psychoneurotic or schizophrenic. Of these, ten, or less than one-half, terminated service themselves. The Clinic terminated the remaining fourteen cases and referred only five patients to other agencies. Referring to Table XIII, one finds that only five patients in these two categories terminated after three or fewer interviews. These figures indicate that the patients in these two diagnostic categories made good use of Clinic service, and that the Clinic made services available for these types of patients.

The disposition of cases in this study paralleled the disposition of cases in a previous study. A previous study

indicated that 47 per cent of the patients terminated service themselves as compared with 48.5 per cent in this study; in the previous study 20 per cent were Clinic-terminated without referral elsewhere as compared with 19.5 per cent in this study; and 33 per cent of the patients in the previous study were Clinic-terminated with referral elsewhere as compared with 32 per cent in this study.

CHAPTER IV

CONCLUSIONS AND RECOMMENDATIONS

This study was designed to compare the patient referred by schools with the patient referred by other sources in relation to a variety of characteristics.

The most surprising finding in this study was the fact that only 19 per cent of the patients were referred by the schools. A larger proportion of school referrals was expected since the Chattanooga School System has several trained social workers employed who are oriented to the type of services the Clinic offers. It is believed that the school social workers were counselling many students and/or their parents and tended to refer only the more seriously disturbed student to the Clinic.

In general, the two groups were much more alike than was anticipated. The findings in regard to the hypotheses stated in Chapter I indicated that the two groups were very similar in many characteristics and that what differences were found proved to be insignificant according to chi-square computations.

It was predicted that the distribution of patients according to ages of the children studied would cluster at two points, at ages six and seven and at ages twelve and

thirteen. The clusters occurred at ages eight and nine and at ages fourteen and fifteen. An explanation for this may be that referral sources are hesitant to refer a child in the first or second grade, or at ages six and seven, thinking that the child's problem may be a slow adjustment to his new roles or that his problem can be outgrown. In regard to the older child, the same explanation is offered as well as the possibility that the change from junior high school to senior high school is a greater change to make and one of greater stress to the child, making more problems evident than the change from elementary to junior high school.

The distribution of latency-age children and adolescents was almost identical, 101 latency-age children and ninety-nine adolescents. This indicated that children of all ages have emotional problems at about similar rates and that those making the referrals are aware of emotional problems regardless of the child's age.

It had been predicted that schools would refer more patients of the lower income class than other sources. This prediction was not supported by the data. More than one-half, 54 per cent, of the children studied were from homes of the lower income class. This is in contrast to a popular notion that outpatient psychiatric clinics are more likely to provide service to the middle and upper income classes than to the lower income class. It would be interesting to

have the results of a future study in regards to patients of various income levels.

Forty-eight and one-half per cent of the children in this study were the oldest child in the family. This in in contrast to another popular notion that the oldest child is more likely to have emotional problems than younger siblings. Further research concerning characteristics of the oldest child versus those of younger siblings would be not only interesting but also helpful and useful to the Clinic, because the oldest child category in this study was the largest single category.

The two referral groups were about equal in terms of referring children from one-parent families. Twenty-seven per cent of the patients referred by other sources were from one-parent families as compared with 24 per cent of those referred by schools. A study comparing children with one-parent with children who have both parents could reveal more specifically how they may differ in a larger sample. This is important because of the high proportion of one-parent families in caseloads of other kinds of agencies, to which the Clinic offers consultation.

Those patients referred by schools tended to terminate contact with the Clinic at earlier stages in the Clinic process and at a higher rate than those referred by other sources. This was expected. Some patients referred by the

schools feel compelled to contact the Clinic and they tend to break contact after only a few interviews. Doctors, medical facilities, and the court made the majority of referrals in the group designated "other sources." Findings indicate that the patient referred by this group tend to make better use of Clinic service than the patient referred by schools. This may be explained by the fact that more professional people are in the "other sources" group and that they are more proficient in making the appropriate referral, more aware of the services that the Clinic offers, and are receiving better interpretation of Clinic services than the schools.

Further study, focused on individual cases, is needed to determine how age of the child, diagnosis, and attitudes of parents relate to length of time the school referrals maintain contact.

Apart from findings relevant to the hypotheses, other interesting facts were found. Among them are the following:

In keeping with a nationwide trend, more patients were male than were female.

Proportionately, more white children were referred to the Clinic than Negro children. However, an increase in the proportion of Negroes served occurred in this study over two previous studies.

The Negro patient is not referred to the Clinic

in the same proportion as they are found in the community.

Approximately two-thirds of the Negro patients were latency-age children. About one-half of the children in this study were adolescents, but only one-third of the Negroes were adolescents. This indicates that the younger Negro is more likely to receive Clinic services.

Both referral groups tended to refer the child who was lagging in school grade. This indicates that parents and teachers are more likely to seek help for a child who is behind in school progress than for the child who is in appropriate grade and is doing satisfactory school work.

Each of these findings suggest areas in which further research could be conducted. The following questions need to be answered:

Why are more males referred to psychiatric clinics than females?

Why are fewer Negroes referred to the Clinic than the proportion of Negroes in the community?

Why are there fewer Negro adolescents referred to the Clinic than white adolescents or latency-age Negroes?

What characteristics are found in children who are lagging in school that differ from characteristics of children who are doing satisfactory school work?

As an outgrowth of this study, the following recommendations are made:

1. That a more concentrated effort be made in testing the patients motivation during the telephone interview and intake interview.
2. That Clinic services be continuously interpreted to the Negro with particular focus toward the teachers and school officials on the junior and senior high school levels.
3. That the Clinic continue to help school personnel recognize emotional problems among students with particular emphasis on the child who is doing satisfactory work but who may still have emotional problems.
4. That ways be found to reach a wider variety of the "gate-keepers" or "caretakers" of the community so that children in need of Clinic service who are not known to schools, courts, or doctors (the commonest sources of referral) can receive attention.

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